FACE INVESTIGATION

SUBJECT: Logger dies after fall from skidder to tree stump

SUMMARY: A logger (the victim) died after he apparently fell while climbing out of a log skidder, sustaining fatal chest injuries upon impact with a tree stump. The victim was working with another logger who was cutting trees while the victim used the skidder to drag logs to a landing area. The compartment flooring and step/rung of the skidder had shiny metal surfaces where the paint coating had worn away. The field where the incident occurred had tree stumps and cut branches, and an uneven soil surface. Shortly after the victim and co-worker returned from a break, the victim was found unresponsive by the co-worker, lying face down on a pile of logs near the log skidder. There were no witnesses to the incident. He was transported by air ambulance to a hospital, where he was pronounced dead. The FACE investigator concluded that, in order to prevent similar occurrences, the employer should:

! ensure that work surfaces (e.g. equipment flooring and steps) have slip-resistant finishes

! conduct a jobsite survey to evaluate equipment and work processes and remove or control safety hazards

! develop and implement a written safety program that provides for training employees in hazard recognition and control.

INTRODUCTION: On May 6, 1993, a 39 year old male logger died of a fall from a log skidder. The Wisconsin FACE investigator learned of the incident on June 18, 1993, from the Wisconsin Department of Industry, Labor, and Human Relations and the investigation was initiated August 18, 1993. A death certificate, news clippings, and reports from Worker's Compensation, OSHA, the coroner's office and sheriff's department were obtained. The FACE investigator interviewed the employer September 25, 1993.

The employer (a logger) has operated a logging and firewood business for two years. The victim had begun working for the employer three days before the incident, and was the first and only employee of the business. The employer had been working at the incident site for four days before hiring the victim to assist him at the site. The employer did not have a formal safety program, and had no written procedures for the victim that were specific to his work tasks. The victim received on-the-job training from the employer on use of the skidder, and had used the equipment on the two days prior to the incident.

INVESTIGATION: The employer and the victim had been working together cutting trees and hauling logs at the site of the incident for three days. Weather conditions were clear and dry. After a short break together around 11 AM, the employer and the victim returned to work. The employer began cutting down trees while the victim operated the skidder to drag six logs to the landing area, about 50 feet from the cutting site. The paint surface has worn off the floor of the driver compartment of the skidder, leaving a smooth metal surface. The step/rung of the skidder is approximately fifteen inches from the ground, and

also has a smooth metal surface. Apparently the victim fell as he was stepping off the skidder from the compartment or rung, and struck his chest on a tree stump approximately eight inches in diameter and several inches high. He was able to get up and move to the pile of logs attached to the skidder by drag cables, where he collapsed. The employer had cut down about five trees when he looked over and noticed the victim lying face down on top of the pile of logs. The employer ran to the victim and found him unresponsive and not breathing. He rolled the victim on his back, and moved him about five feet away from the cables so he could drive the skidder off the trail to make room for his truck. The employer drove the truck down the road and found another logger, who returned with the employer to where the victim was lying and stayed with him while the employer drove about one-half mile to find a telephone to call an ambulance. The EMT from the ambulance service started CPR and called for a helicopter to transport to a regional hospital. The victim was pronounced dead at the hospital about three hours after the incident. There were no witnesses to the incident, and the scenario is based on the location where the victim was found and the description of the internal injuries that caused his death. There was no evidence of external wounds or bruising to indicate what might have caused the injury.

CAUSE OF DEATH: The death certificate notes the cause of death as chest trauma with pulmonary hemorrhage. An autopsy found that death was caused by a crushing injury to the upper chest with sternum and rib fractures that resulted in internal lacerations and internal bleeding. Blood alcohol tests revealed less than .015 grams per deciliter.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Employers should ensure that work surfaces (e.g. equipment flooring and steps) have slip-resistant finishes.

Discussion: In this incident, the victim fell while stepping down from a work surface that had a shiny metal surface that could cause slips. Employers should maintain slip-resistant work surfaces, using coatings that leave a textured or abrasive finish, or roughening the flooring material to make it slip-resistant.

Recommendation #2: Employers should conduct a jobsite survey to evaluate equipment and work processes and remove or control safety hazards.

Discussion: The compartment flooring of the skidder had a shiny metal surface, and the terrain surrounding the worksite area had tree stumps and cut branches. The employer should evaluate worksite conditions on a regular basis to identify hazardous conditions and implement appropriate control measures.

Recommendation #3: Employers should develop and implement a written safety program that provides for training employees in hazard recognition and control.

Discussion: At the time of the incident, the employer did not have a formal safety program. A safety program that includes safe procedures for getting into and out of equipment should prevent slips and falls.